



राजपत्र, हिमाचल प्रदेश (असाधारण)

हिमाचल प्रदेश राज्य शासन द्वारा प्रकाशित

शिमला, मंगलवार, 7 मार्च, 2006/16 फाल्गुन, 1927

हिमाचल प्रदेश सरकार

FINANCE (IF & PE) DEPARTMENT

NOTIFICATION

Shimla-171072, the 1st March, 2006

No. Fin-IF(F) 9-1/2005-1.—The Governor, Himachal Pradesh is pleased to renew the indexed Group Personal Accident Insurance Scheme for all Regular, Ad hoc, Part Time, Contractual and Daily Wages employees of Governments Departments/Borrrds/Corporations, Universities and autonomous bodies on compulsory basis w. e. f. 5-4-2006 for a period of one year through United India Insurance Company Ltd., Timber House, Cart Road, Shimla-171001.

Salient features of the scheme :—

1. Premium :—Rs. 70/- per employee (inclusive of all taxes and levies)
For a sum assured of Rs. 2.00 lakh.
2. Coverage :—As per Annexure-A.

3. Benefits in case of :—

(i) Death	2.00 lakh
(ii) Permanent total disablement	2.00 lakh
(iii) Loss of one limb+one eye/both eyes or both limbs.	2.00 lakh
(iv) Loss of one limb/eye	1.00 lakh

This scheme will not cover the Daily Waged Workers and Work charged staff of Departments, PSUs, Universities and autonomous bodies who have a separate scheme.

Mode of Premium Payment :

- (a) The insurance premium would be paid directly by each DDO alongwith list of employees to the United India Insurance Company Ltd., Timber House, Cart Road, Shimla-171001 (Telephone No. 2625366, 2625302) @ Rs. 70/- per employee by deducting the same from the salary for the month of March, 2006 on compulsory basis by Bankers' cheque/draft on or before 5-4-2006.
- (b) The Insurance Company would cover all employees under the scheme from the date of issue of Bank Draft in place of actual date of receipt of the draft. The State Government will place a refundable advance of Rs. 1.00 lakh with the company to fulfil the legal requirement of coverage from the date of receipt. Insurance Company will refund this amount to State Government after the scheme is over.

Claims :

All claims will be dealt directly by the Divisional Office, United India Insurance Company Ltd., Timber House, Cart Road, Shimla-171001 only without any involvement of any higher or lower level office and settled within a weeks time after completion of requisite claim formalities which are as per Annexure-A. All the DDO(s) will lodge the claim(s) with the Insurance Company within 30 days of occurrence of any accident in the specified forms enclosed with the Notification after completing all codal formalities. DDO(s) would ensure that no claim(s) is rejected on the grounds being time barred. The DDO(s) will be responsible to follow all claims vigorously and settle them with Insurance Company at the earliest.

All Administrative Secretaries and HODs would ensure to supply a copy of this Notification to all the DDOs under their administrative control for strict compliance.

Action may be ensured at the above.

By order,

Sd/
(SUTANU BEHURIA),
Principal Secretary.

UNITED INDIA INSURANCE CO-OPERATIVE LIMITED

**TIMBER HOUSE, CART ROAD
SHIMLA-171001**

**SCOPE OF COVER OF GROUP PERSONAL ACCIDENT POLICY FOR EMPLOYEES
OF STATE OF HIMACHAL PRADESH.**

- (a) IF ACCIDENTAL INJURY SHALL WITHIN 12 (TWELVE) CALENDAR MONTHS OF ITS OCCURRENCE BE THE SOLE AND DIRECT CAUSE OF THE DEATH OF THE INSURED PERSON, THE CAPITAL SUM INSURED OF RS. 2,00,000/- STATED IN THE SCHEDULE HERE TO SHALL BE APPLICABLE TO SUCH INSURED PERSON.
- (b) IF SUCH INJURY SHALL WITHIN 12 (TWELVE) CALENDAR MONTHS OF ITS OCCURRENCE BE THE SOLE AND/OR DIRECT CAUSE OF THE TOTAL AND IRRECOVERABLE LOSS OF.
 - (i) THE SIGHT OF BOTH EYES OR THE ACTUAL LOSS BY PHYSICAL SEPARATION OF THE TWO ENTIRE HANDS OR TWO ENTIRE FEET OR ONE ENTIRE HAND AND ONE ENTIRE FOOT OR SIGHT OF ONE EYE AND SUCH LOSS OF ONE ENTIRE HAND OR ONE ENTIRE FOOT OF THE INSURED PERSON THE CAPITAL SUM INSURED STATED IN THE SCHEDULE HERE TO SHALL BE APPLICABLE TO SUCH INSURED PERSON.
 - (ii) USE OF TWO HANDS OR TWO FEET OR OF ONE HAND AND ONE FOOT OR SUCH LOSS OF SIGHT OF ONE EYE AND SUCH LOSS OF USE OF ONE HAND OR ONE FOOT OF THE INSURED PERSON THE CAPITAL SUCH INSURED STATED IN THE SCHEDULE HERE TO APPLICABLE TO SUCH INSURED PERSON.
- (c) IF SUCH INJURY SHALL WITHIN 12 (TWELVE) CALENDAR MONTHS OF ITS OCCURRENCE BE THE SOLE AND DIRECT CAUSE OF THE TOTAL AND IRRECOVERABLE LOSS OF :—
 - (i) THE SIGHT OF ONE EYE OF THE ACTUAL LOSS BY PHYSICAL SEPARATION OF ONE ENTIRE HAND OR ONE ENTIRE FOOT OF THE INSURED PERSON 50% (FIFTY PERCENT) OF THE CAPITAL SUM INSURED STATED IN THE SCHEDULE HERE TO APPLICABLE TO SUCH INSURED PERSON.
 - (ii) USE OF ONE HAND OR ONE FOOT OF THE INSURED PERSON WITHOUT PHYSICAL SEPARATION 50% OF THE CAPITAL SUM INSURED STATED IN SCHEDULE HERETO APPLICABLE TO SUCH INSURED PERSON.

NOTE FOR PURPOSE OF CLAUSES (B) ABOVE PHYSICAL SEPARATION OF A HAND OR FOOT MEANS SEPARATION OF HAND AT OR ABOVE THE WRIST AND OR OF THE FOOT AT OR ABOVE THE ANKLE.

- (d) IF SUCH INJURY SHALL AS A DIRECT CONSEQUENCE THEREOF IMMEDIATELY, PERMANENTLY TOTALLY AND ABSOLUTELY DISABLE THE INSURED PERSON FROM ENGAGING IN OR BEING OCCUPIED

WITH OR GIVING ATTENTION TO ANY EMPLOYMENT OR OCCUPATION OF ANY DESCRIPTION WHATSOEVER. THEN A LUMPSOM EQUAL TO 100% OF THE CAPITAL SUM INSURED STATED IN THE SCHEDULE HERE TO APPLICABLE TO SUCH INSURED PERSON.

- (e) REIMBERSEMENT OF EXPENSES OF CARRIAGE OF DEAD BODY POLICY WILL REIMBERSE THE ACTUAL EXPENSES INCURRED FOR THE CARRIAGE OF THE DEAD BODY OF THE INSURED PERSON (DEATH DUE TO ACCIDENT) TO THE PLACE OF RESIDENCE SUBJECT TO MAXIMUM OF RS. 1,000
- (f) CLAIM INTIMATION TO BE SUBMITTED IMMEDIATELY BUT NOT LATER THAN THIRTY DAYS OF ACCIDENT.

ENCLS:—(A) CLAIM INTIMATION LETTER
(B) CLAIM FORM

ANNEXURE—I

CLAIM INTIMATION LETTER
(Specimen Copy)

The Divisional Manager,
United India Insurance,
Timber House, Cart Road,
Shimla-171001
Tel : 2625397
2625302

Date :

SUB : INTIMATION OF LOSS UNDER GROUP PERSONAL ACCIDENT POLICY

Sir,

It is to intimate you that Sh.....S/o Shri.....
R/o.....working as.....in
Department of.....posted at.....has
died/lost following body parts.....
suffered permanent total disability/permanent/partial disability as per quotation letter
No. FIN-IF(F)9-1/2005-1, dated 16-1-2006 due to accident of.....on
dated.....You are requested to register the claim at the
earliest in favour of insured against Group Personal Accident Insurance Scheme.

Thanking you.

(.....)
SIGNATURE

(Not in case of death)

DATED:.....

PLACE:.....

(.....)
Countersigned by Head of the
Office/Department

Documents to be submitted in event of a claim .

- (1) Claim intimation immediately after knowledge of occurrence.

(2) Claim form alongwith :

- (i) FIR
- (ii) Postmortem report in event of death/death certificate from State authority.
- (iii) Treatment and disability certificate in event of permanent disability/permanent partial disability.

NOTE : ALL DOCUMENTS SHOULD BE DULY ATTESTED BY HEAD OF DEPTT.

ANNEXURE-II

(CLAIM FORM GROUP PERSONAL ACCIDENT POLICY)
(Not be taken as admission of any liability)

1. NAME OF INSURED
NAME OF LIFE INSURED
DESIGNATION
PARENTAGE
RESIDENTIAL ADDRESS
.....
POSTED AT
DEPARTMENT
PREMIUM PAID ON POLICY NO.
2. AGE SEX
DATE OF ACCIDENT TIME OF ACCIDENT
HOW DID ACCIDENT OCCUR
WITNESS OF ACCIDENT HIS NAME :
ADDRESS
.....
3. NATURE OF INJURY RECEIVED
NATURE OF DISABLEMENT
NAME & ADDRESS OF HOSPITAL
PRESENT STATE OF INJURY/HEALTH
WHEN AND WHERE CAN INSURED-
PERSON BE VISITED BY OFFICIAL INSURERS
.....
4. DETAIL OF POLICE REPORT LODGED
WITH F. I. R. NO. AND DATE
ULTIMATE LOSS (Loss of body parts PTD)
DETAILS OF BODY PARTS LOST
DETAILS OF PERMANENT TOTAL DISABILITY
POSTMORTEM/TREATMENT TAKEN FROM
.....

5. I hereby declare that the foregoing statements are true to the best of my knowledge and belief and I have not attempted to conceal any relevant pertinent information. In case of any false/fraudulent/untrue averment whatsoever the said policy shall be void *ab-initio* and my right/my claim for compensation will be forfeited.

(.....)

SIGNATURE

(Note : In case of death)

DATED

(.....)

Countersigned by Head of the
Office/Department

PLACE

FOLLOWING DOCUMENTS ENCLOSED IN SUPPORT OF THIS CLAIM :

1. FIR
2. Post Mortem Report
3. Brief Accident Report by the Department
4. Any other Document.